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MEMORANDUM

TO: Legislative Oversight Committee
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional and Stakeholder Organizations

FROM: Allen Dobson, MD LAD ml
Mike Moseley MM/ml

SUBJECT: Enhanced Services Implementation Update # 11

This update covers a variety of topics including clarification of requirements for children's residential treatment facility services, service orders, a revised Person Centered Planning template, EPSDT, Utilization Review and other information.

Child Residential Rules and Service Definitions

The new rules for Child Residential Treatment Level III facilities require that "face to face clinical consultation shall be provided in each facility at least four hours a week by a licensed professional." (10ANCAC 27G .1705). There has been confusion about whether or not these four hours of face to face consultation by the licensed professional are required at the facility level or the individual child level. The rule requires the four hours provided by the licensed individual to be provided to the facility and not necessarily to each individual child served in the facility.

The service definition for High Risk Intervention – Residential Level III also requires that four hours of treatment be provided to each individual child in the facility each week. This requirement may be met by having the licensed professional provide treatment to individual children, but it may also be met by treatment in a group or individual setting provided by a qualified professional (QP) or an associate professional (AP). The revised payment rate for the service reflects both of these expectations – four hours by a licensed individual to the facility in aggregate and four hours per child by a QP or AP.

Service Orders

The request for services outlined in the Person Centered Plan (PCP) is the official request for services. The signatures on the PCP serve as the service order for those services. For Medicaid covered services, one of those signatures must, therefore, be a physician (MD), physician's assistant (PA), nurse practitioner, or licensed psychologist to meet the Medicaid requirement for a valid service order. The service order must be signed each year as the PCP is reviewed and updated. Any time the PCP is revised to request a new service, there must be a signed service order reflecting the medical necessity of the services. This is reflected on the PCP revision/update page of the PCP.

PCPs for consumers who are not Medicaid eligible must also be signed to reflect a service order. In recognition that the Medicaid eligibility status for many consumers changes over the course of a year, it is highly recommended that PCPs for consumers for whom this is likely be signed by one of the four approved Medicaid signatories. This will allow ValueOptions to authorize Medicaid services based upon a valid service order as soon as the consumer becomes Medicaid eligible. Alternatively, PCPs for non-Medicaid consumers may be signed by the QP who facilities the development of the PCP

The signatures on a Diagnostic Assessment or other clinical assessment or evaluation cannot be substituted for the signature on the PCP since the services recommended as part of the DA or other assessment may or may not ultimately be included in the PCP. Consumers, family members, significant others, and professionals should have equal and respectful input into the ultimate request for services included in the PCP. QPs facilitating the development of the PCP must include in the final PCP any services that a consumer or family member requests and a clinician believes to be medically necessary and should make every effort to assure that other requests from consumers, family members and others are reflected, as appropriate, in the final PCP. The signature on the PCP serving as the service order then attests to the medical necessity of the final array of services requested.

Consumer Flow Video

In an effort to clarify the ways in which consumers move through the new system, DMH/DD/SAS has developed a video presentation. The video can be viewed online at: http://behavioralhealthcareinstitute.org/videos/chart_frameset.htm. Also attached to this Update is a two page grid designed to describe the initial services and PCP requirements for new and existing Medicaid and non-Medicaid consumers receiving enhanced and basic benefit services.

Changes to Person Centered Plan

We have made some minor but important modifications to the PCP template as a result of questions and feedback we have received. The new template and updated instructions have been posted to the DMH/DD/SAS website. The new instructions provide more guidance in understanding several important aspects of Person Centered Planning as well as more detail in the overall understanding of each section of the plan. All PCPs that have been developed using the original template are still valid and do not need to be revised. The new template may be used immediately; its use will be required for all plans developed on or after August 1, 2006.

Clarification to Grid for Provisionally Licensed Providers

A grid outlining the services that may be delivered by licensed and provisionally licensed clinicians was included as an attachment to Implementation Update # 7, dated March 27, 2006. Licensed Marriage and Family Therapists (LMFT) were inadvertently omitted from the list of clinicians who may perform Diagnostic Assessment. The grid currently on the DMH/DD/SAS website has been updated to correct that error.

New Psychiatry Rates

As announced as part of the Department's *Action Agenda for Mental Health Reform*, the DHHS Rate Review Board has approved increased rates for several CPT code services delivered by psychiatrists. The new rates are effective July 1, 2006 and are as follows:

90862	Medication Check – Individual	$56.54
90805	Individual Therapy (20-30 minutes) MD	$73.48
90807	Individual Therapy (45-50 minutes) MD	$103.58

The rates for these codes for services delivered by other clinicians are based upon the new psychiatry rates in accordance with the usual formula.

Choice

Reminder to all providers, Medicaid services are to be provided by any willing and qualified provider. Thus, no provider agency may make any conditions of service contingent upon utilization of other services from any specific agency. Consumer choice must not be hindered by any conditions other than limits or restrictions based upon their Medicaid eligibility status.

EPSDT reviews

When EPSDT reviews are requested for existing services, such services should continue until the review and notification of the decision has been sent by ValueOptions (VO). If the EPSDT review is for a service not currently being received by the recipient, thus a new service, services should not begin until it has been properly authorized.

Please remember to send a complete packet of information when making a request for an EPSDT review. This includes a cover sheet indicating contact information and the type of service requested, the PCP/Treatment plan and any supporting information to justify the medical necessity of the request. VO has 15 days from the date of the request to render a decision or request additional information as necessary. Failure to respond to a request for additional information will result in a denial.

An EPSDT exception is not necessary to honor a request of more than 2 hours of Community Support provided in tandem with other services. Submit the Community Support request, including justification for more than 2 hours, as a part of the other service request and should be included in the treatment plan/PCP. VO will process the community support when medically necessary as part of the overall service approval.

Utilization Review Reminders

Please do not send duplicate requests to VO for review. If you have received a confirmation from ValueOptions of the receipt of the fax and you have not heard in 3-5 days for regular reviews or 15 days for EPSDT reviews, please contact VO via phone or email. The receipt of duplicate request for the same period of service significantly reduces the efficiency of the review process. To date, approximately 25 % of the incoming request are duplicates.

When submitting request for utilization review, please submit sufficient information (a copy of the PCP/Treatment Plan and any other information that justifies medical necessity for the service) initially. Anytime additional information has to be requested, it delays the turn around time.

An August video training is being planned by VO/DMA/DMH for providers. More information will follow on dates for this training.

If you have any questions concerning these matters, please email contactdmh@ncmail.net.

cc: Secretary Carmen Hooker Odom
Allyn Guffey
Dan Stewart
DMH/DD/SAS ELT
DMA Leadership
Wayne Williams
Lynette Tolson
Kaye Holder

NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Requirements for Service Provision

I. MEDICAID CONSUMER	DIAGNOSTIC ASSESSMENT (DA) T1023	CLINICAL INTAKE/EVALUATION/ ASSESSMENT: 90801, H0001, OR H0031	COMMUNITY SUPPORT (CS) OR TARGETED CASE MANAGEMENT (TCM)*	PERSON-CENTERED PLAN (PCP) INCLUDING CRISIS PLAN**
NEW MEDICAID CONSUMER (for 1st 30 Days) **ENHANCED BENEFIT SERVICES** • Meets Medical Necessity Criteria for **Enhanced Benefit Services**	**REQUIRED***. Provide service within 30 days of service initiation	**Not Required.** Provide as necessary for evaluation of special consumer needs & submit to VO.	**REQUIRED.** Provide service for up to 30 days from services initiation.	**REQUIRED.** Complete and submit electronically to VO within 30 days of service initiation.
NEW MEDICAID CONSUMER **BASIC BENEFIT SERVICES ONLY** • Meets Medical Necessity Criteria for **Basic Benefit Services Only**	**Not Required.**	**Not Required.**	**Not Required.**	**Not Required.**
CURRENT MEDICAID CONSUMER **ENHANCED BENEFIT SERVICES** • Meets Medical Necessity Criteria for **Enhanced Benefit Services** and services received are **GREATER THAN** Outpatient (OP) and/or Medication Management (MM) Only	**Not Required.** Provide only when necessary to clarify diagnosis or consider a second opinion, or if consumer is not making progress in treatment and additional assessment is needed to inform a revision in treatment plan.		**REQUIRED.** Provide continued services with authorization as medically necessary.	**REQUIRED.** Complete and submit electronically to VO at time of annual update.
CURRENT MEDICAID CONSUMER **ENHANCED BENEFIT SERVICES – OP/MM ONLY** • Meets Medical Necessity Criteria for **Enhanced Benefit Services** and services received are **LIMITED TO** Outpatient (OP) and/or Medication Management (MM) Only.	**Not Required.** Service is optional as needed.	**Not Required.** Service is optional as needed.	**Not Required.** Service is optional as needed.	**Not Required.** Plan is optional as needed.
CURRENT MEDICAID CONSUMER **BASIC BENEFIT SERVICES ONLY** • Meets Medical Necessity Criteria for **Basic Benefit Services Only** and services received are **LIMITED TO** Outpatient (OP) and/or Medication Management (MM) Only.	**Not Required.**	**Not Required.**	**Not Required.**	**Not Required.**

*** Community Support (CS), Targeted Case Management (TCM), or any other Enhanced Benefit Service that includes case management services.**
**** Time spent developing the Person Centered Plan and the level of detail included in the Plan should be commensurate with the services to be delivered.**
***** Not required for consumers discharged from any inpatient hospital or state-operated ADATCs and Developmental Centers if a substantially equivalent assessment was completed during the inpatient stay.**

Approved DMHDDSAS/DMA: Effective 06/30/06

NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Requirements for Service Provision

II. STATE ONLY CONSUMER	DIAGNOSTIC ASSESSMENT (DA) T1023	CLINICAL INTAKE/ EVALUATION/ ASSESSMENT: 90801, H0001, OR H0031	COMMUNITY SUPPORT (CS) OR TARGETED CASE MANAGEMENT (TCM)*	PERSON-CENTERED PLAN (PCP) INCLUDING CRISIS PLAN
NEW STATE ONLY CONSUMER **ENHANCED BENEFIT SERVICES** • Meets DMHDDSAS Target Population Eligibility	**REQUIRED***.** Provide one of these services as authorized by **LME.**		**HIGHLY RECOMMENDED.** Provide, subject to availability of funds, as medically necessary and as authorized by LME.	**REQUIRED.** Complete and submit to LME within 30 days of initiation of services.
CURRENT STATE ONLY CONSUMER **ENHANCED BENEFIT SERVICES** • Meets Medical Necessity Criteria for **Enhanced Benefit Services** and services received are **GREATER THAN** Outpatient (OP) and/or Medication Management (MM) Only	**Not Required.** Provide only as medically necessary and authorized by LME for clarification of diagnosis or revision in treatment plan.		**HIGHLY RECOMMENDED.** Provide, subject to availability of funds, as medically necessary and as authorized by LME.	**REQUIRED.** Complete and submit to LME at time of annual update or at request for reauthorization.
CURRENT STATE ONLY CONSUMER **ENHANCED BENEFIT SERVICES – OP/MM ONLY** • Meets Medical Necessity Criteria for **Enhanced Benefit Services** and services received are **LIMITED TO** Outpatient (OP) and/or Medication Management (MM) Only.	**Not Required.** Provide only as medically necessary and authorized by LME for clarification of diagnosis or revision in treatment plan.		**Not Required.** Provide only as medically necessary and as authorized by LME.	**Not Required.** Plan is optional as needed.
NEW STATE ONLY CONSUMER **CORE SERVICES ONLY** • **Does Not Meet** DMHDDSAS Target Population Eligibility • Services received are **Assessment Only, Crisis/Emergency Services, or Consultation, Education and Prevention Services**	**Not Required.**		**Not Required.**	**Not Required.**

*** Community Support (CS), Targeted Case Management (TCM), or any other Enhanced Benefit Service that includes case management services.**
**** Time spent developing the Person Centered Plan and the level of detail included in the Plan should be commensurate with the services to be delivered.**
***** Not required for consumers discharged from any inpatient hospital or state-operated ADATCs and Developmental Centers if a substantially equivalent assessment was completed during the inpatient stay.**

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